STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/05/2013

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R000000	This visit was for a State Residential Licensure Survey. Survey dates: September 3, 4, 5, 2013. Facility number: 010234 Provider number: 01234 AIM number: N/A Survey team: Gloria Bond R.N., TC Michelle Hosteter R.N. Sandra Nolder R.N. Census bed type: Residential: 51 Total: 51 Census payor type: Other: 51 Total: 51 Sample: 9 These State Residential findings are cited in accordance with 410 IAC 16.2 Quality Review was completed by Tammy Alley on September 9, 2013.	R000000	The following is the Plan of Correction for Brookdale Place of Willow Lake in regards to the Statement of Deficiencies for the annual survey completed on September 5th, 2013. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective. On September 20, 2013 a copy of our plan of correction, signed 2567, and items needed to request an Informal Dispute Resolution for Tag R 301 Pharmaceutical Services were faxed to the ISDH. Unfortunately, because of Executive Director changes, I Camille Beeson, Executive Director of Brookdale Place at Willow Lake, license number 14005218A, was never issued an access password for the gateway	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			system. After multiple attempts to gain access I had to fax my POC in order to stay in compliance. The facility was required to submit a POC for the state deficiencies no later than September 21, 2013.	

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R000026	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on interview and record review the facility failed to ensure the Indiana Resident Rights document was dated when the resident signed it upon admission for 1 of 7 residents reviewed for documentation of signed and dated resident rights. (Resident #17) Findings include: Resident #17's record was reviewed on 9/4/13 at 12:30 P.M. The resident's record lacked a dated copy of her Indiana Resident Rights	R000026	R 026 Resident Rights (Non-compliance)What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· Resident #17: an updated copy of the Resident Rights document will be reviewed with this resident and/or responsible party. It will be signed and the new date indicated on the updated document. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?· An audit of resident	10/04/2013

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	document. The Administrator provided a copy on 9/4/13 at 12:30 P.M., of Resident # 17's Indiana Resident Rights document. The document had her signature, but did not have a date of when it was signed. During an interview on 9/4/13 at 12:30 P.M., the Administrator indicated he did not know the date when the Indiana Resident Rights document was signed by Resident #17.		business office files will be completed by the Business Office Manager to verify the presence of signatures and dates for the Resident Rights acknowledgement form. · In the event other current residents are found to be missing dates of signatures on the Resident Rights acknowledgement form, the Business Office Manager (BOM) will notify the Executive Director who will determine if a new Resident Rights document will need to be signed. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?· The Sales Marketing Manager (SMM) and/or the Executive Director (ED) will be responsible for obtaining signatures on the Resident Rights acknowledgement forms upon move-in.· A move-in "tickler file" will be utilized to document the presence (with signatures and dates) of Resident Rights forms.· The BOM will be responsible for auditing all such documents within 7 days of move-in. · The results of the audits are to be routinely provided by the BOM to the ED. · The ED will utilize this information in order to identify trends and provide direction as to the appropriate action. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality	

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			assurance programs will be put into place?· The Executive Director (E.D.) will be provided a copy of the BOM's audit of current Resident Rights acknowledgement form documentation.· The tickler file will be utilized for weekly audits of new move-ins as well as existing resident files.· This process will continue monthly and on-going to audit for continued compliance with the state requirement.· Additional action will be taken by the E.D. as warranted, based on results of audits.	

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R000092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review the facility failed to conduct a fire and disaster drill in conjunction with the fire department at least every six months. This had the potential to affect 51 of 51 residents residing in the facility. Findings include: The fire and disaster drill documentation logs were reviewed on	R000092	R 092 Administration and Management (Non-compliance)What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· It is not possible to go back and schedule a fire drill as when due (November 2012), however, going forward, a new fire drill with the fire dept. will be requested to be completed within 6 months of the last documented fire drill with the fire department which	10/04/2013

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	9/3/13 at 11:30 A.M. The documentation logs indicated the Maintenance Technician conducted a fire drill in conjunction with the fire department on 4/16/13, which was over six months since the last fire and disaster drill. During an interview on 9/5/13 at 10:50 a.m., the Administrator indicated he had no documentation of an expected fire and disaster drill being attempted in November of the last year.		occurred on 4-16-13. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?· All residents have the potential to be affected by the alleged non-compliance.· The Maintenance Dept. will provide documentation of all Fire Drill requests to the Executive Director, and will make Fire Drill documentation readily available in the Fire Drill binder for monthly review. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?· The Maintenance Department has been re-educated on the state requirement by the E.D.· The Maintenance Department Manager will be required to place all Fire Drill Documentation in a Fire Drill binder on a monthly basis. · Documentation of Fire Drill requests made to the local Fire Department, as well as their responses, will also be documented in the Fire Drill binder for ease of review by the Executive Director on a monthly basis. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?· The Executive Director (E.D.) will be provided a copy of all Fire Drill requests by	

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			the Maintenance Director and these will be filed in the Fire Drill binder to ensure they are occurring as required by state regulation.· This process will continue monthly and on-going to audit for continued compliance with the state requirement.· Additional action will be taken by the E.D. as warranted, based on results of audits.	

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R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview the facility failed to ensure there was a CPR (cardiopulmonary resuscitation) and first aid certified staff member in the facility available for residents at all times. This had the potential to affect all 51 of 51 residents who lived in the facility. Findings include: 1. A review of the employee records	R000117	R117 Personnel-DeficiencyWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· Nurses will be recertified in CPR and First Aid as required by state regulation.· A licensed nurse will be scheduled for each shift. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective	10/04/2013

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	was completed on 9/4/13 at 3 P.M. The First Aid and CPR certifications were reviewed. The review of all of the current employees indicated there were only two staff, the Health and Wellness Director and LPN #4 with current First aid and CPR certification in the facility. The Administrator provided the staff schedule on 9/5/13 at 10:50 A.M. Review of the schedule for 8/22/13 through 9/5/13, indicated the following days did not have staff that were certified in both areas available: August 22- 6 A.M.--2 P.M. and 10 P.M.-- 6 A.M. August 23- 6 A.M.--2 P.M. August 24- 6 A.M.--Noon August 25- 6 A.M.-- 6 P.M. August 26- 6 A.M.--2 P.M. and 10 P.M.-- 6 A.M. August 27- 6 A.M.--2 P.M. and 10 P.M.-- 6 A.M. August 28- 6 A.M.--2 P.M. and 10 P.M.-- 6 A.M. August 29- 6 A.M.--2 P.M. and 10 P.M.-- 6 A.M. August 30- 6 A.M.--2 P.M. September 1- 6 A.M.-- 6 P.M. September 2- No certified staff on schedule September 3- No certified staff on		action will be taken?· An audit of associate files will be completed by the Business Office Manager to verify expiration dates for CPR and First Aid certifications and a tickler file will be initiated to track such due dates in an on-going manner.· In the event other associates are found to be due for recertification, the Business Office Manager (BOM) is to notify the Health and Wellness Director (HWD) in order for the HWD to schedule required training with a certified instructor. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?· The BOM has been re-educated on the use of an audit tool by the E.D.· The results of the audits are to be routinely provided by the BOM to the HWD and the ED. The HWD will utilize this information when scheduling associates.· Nurses will be required to have current CPR and First Aid Certifications in order to be scheduled for their shift.· In the event of non-compliance with scheduled CPR/First Aid training, the associate may be removed from the schedule until such time as certification is current. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?· The	

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	schedule September 4- No certified staff on schedule September 5- No certified staff on schedule During an interview on 9/5/13 at 11:30 P.M., the Administrator indicated this was the schedule as worked as best as he could provide. He also indicated they had gathered as many of the CPR and First Aid certificates that they had on file currently.		Executive Director (E.D.) will be provided a copy of the BOM's audit of current associates and the expiration dates of their current CPR and First Aid certifications.· This process will continue monthly and on-going to audit for continued compliance with the state requirement.· Additional action will be taken by the E.D. as warranted, based on results of audits.	

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R000118	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview the facility failed to ensure a Resident Care Aide (RCA) / Certified Nursing Aide (CNA), currently working, had her Certified Nursing Aide certification for 1 of 5 employee files reviewed for certification. (RCA #4) Findings include: A review of the employee records was completed on 9/4/13 at 3 P.M. A book with all the current certifications and licensure was provided by the Business Office Manager. The book did not have the Nursing Aide certification for RCA #4. A request was made of the Administrator on 9/4/13 at 3:15 P.M., for the current certification for RCA #4. On 9/5/13 at 11:50 A.M., the Administrator provided a schedule	R000118	R118 Personnel-DeficiencyWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· C.N.A. #4 has been offered the option of being reassigned to an indirect care role in dietary until such time as she obtains an Indiana C.N.A. certification. How will the facility identify other associates with the potential to be affected by the same alleged non-compliant practice and what corrective action will be taken?· An audit of associate files will be completed by the Business Office Manager to verify the presence of a current Indiana C.N.A. certification, and a tickler file will be initiated to track such due dates in an on-going manner.· In the event other associates are found to be non-compliant with the certification requirement, the Business Office Manager (BOM) is to notify the Executive Director, and such associates will not be	10/04/2013

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	worked for RCA #4. The schedule indicated RCA #4 had been working with residents on 8/19, 8/20, 8/21, 8/22, 8/24, 8/25, 8/27, 8/28, 8/29, and 8/30, 2013. During an interview on 9/5/13 at 11:55 A.M., the Administrator indicated they did not have RCA #4's current certification for being a Nursing Aide.		allowed to be scheduled for direct care until in compliance. What measures will be put in place or what systemic changes will the facility make to ensure the alleged non-compliant practice does not recur?· The BOM has been re-educated on the use of an audit tool by the E.D.· The results of the audits are to be routinely provided by the BOM to the HWD and the ED. The HWD will utilize this information when scheduling associates.· All C.N.A.'s will be required to have current Indiana certifications in order to be scheduled for their shift.· In the event of non-compliance with certification requirements the associate may be removed from the schedule until such time as certifications are current. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?· The Executive Director (E.D.) will be provided a copy of the BOM's audit of current associates and the expiration dates of their current C.N.A. certifications· This process will continue monthly and on-going to audit for continued compliance with the state requirement.· Additional action will be taken by the E.D. as warranted, based on results of audits.	

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R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview the facility failed to have a service plan signed by the resident for 1 of 7 residents reviewed for signed service plans in a sample of 7. (Resident # 6) Findings include:	R000217	R 217: Evaluation: DeficiencyWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· Resident #6: Personal Service Plan was re-printed, signed and a copy has been placed in the chart. How will the facility identify other residents	10/04/2013

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	Resident # 6's record was reviewed on 9/3/2013 at 1 P.M. Diagnoses included, but were not limited to, left shoulder fracture, constipation, high blood pressure, hypothyroidism. The resident's service plan dated 7/23/2013 lacked the resident or legal representative's signature. On 9/4/2013 at 11:30 A.M. , the Health and Wellness Director provided the resident's service plan dated 7/23/2013 with a signature dated 9/4/2013 and did not offer an explanation for why it had not been signed on the date the service plan was dated.		with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?· Health and Wellness Director and/or Designee will audit other resident clinical records to ensure a copy of the most current Personal Service Plan is printed and signed for the clinical record. · If a responsible party is not immediately available to review and sign the document, a care conference will be requested, at which time signatures may be obtained. This notification will occur by the HWD or designee. · In the event the responsible party requests, the document will be mailed for signature, faxed for signature, or e-mailed for signature. Documentation of notifications will be placed in the clinical record. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?· The Health and Wellness Director has been re-educated on the PSP signature process by the Executive Director and audits will be performed on a weekly basis by reviewing the "Personal Service Plan Due and Error report" available to all Brookdale Executive Directors and Health and Wellness Nurses. · The ED will be notified by the HWD of any scheduled reassessments and/or changes of condition	

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			assessments completed on a routine basis during morning meetings. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?· The Health and Wellness Director / Designee will audit placement of the Personal Service Plan utilizing a checklist and the PSP Due and Error report to audit that a copy of the PSP is present for each resident in the clinical record.· Results of audits will be reviewed by the Executive Director on a weekly basis to monitor for continued compliance. · In the event a non-compliance is noted, the ED will designate next steps and monitor results.	

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R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review the facility failed to ensure that a resident received a medication as ordered by the physician for 1 of 1 residents in a sample of 7 resident records reviewed. (Resident #17) Findings include: Resident #17's record was reviewed on 9/4/13 at 10:00 A.M. Diagnoses included, but were not limited to, congested heart failure, history of venous thrombosis, pulmonary hypertension, and coronary artery disease. On 6/28/13, the resident had an order for the blood thinning medication Warfarin 2.5 mg (milligrams) by mouth every Monday, Wednesday, Thursday, Saturday, and Sunday. Warfarin 5 mg by mouth every Tuesday and Friday. On 7/31/13 at 7:45 A.M., the record indicated the resident's prothrombin time (PT) result was 36.6 seconds	R000247	R 247 Health Services-DeficiencyWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· Resident #17 suffered no adverse effects from the alleged medication omission. · PT/INR is currently within therapeutic limits.· The existing Brookdale “INR Tracking Form” has been updated to ensure next lab dates are documented and assignments entered onto the Medication Administration Record.· The responsible party, as well as the resident’s physician, were previously notified of the alleged incident and new orders were received. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?· Other residents who receive Anticoagulant Therapy have the potential to be affected by the alleged deficiency.· The existing Brookdale “INR Tracking Tools” for all residents receiving anticoagulant therapy were reviewed by the	10/04/2013

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	and international normalized ratio (INR) result was 3.7 seconds. The normal results for PT are 9.0-12.0 seconds and for INR are 2.0-3.0 for patients with venous thrombosis conditions. On 7/31/13 at 8:35 P.M., the results of the PT and INR were called to the physician with new orders. One of the new orders were to hold the warfarin for 2 days ,7/31/13 and 8/1/13, then redraw the PT and INR test on 8/2/13, and call the results to the physicians office. There was no documentation of the PT and INR laboratory results for 8/2/13 indicating the blood work had not been drawn. During an interview on 9/4/13 at 12:00 P.M., the Health and Wellness Director indicated the PT and INR laboratory test was not drawn on 8/2/13. The lab (laboratory) company did not come until 8/8/13 to draw the PT and INR test. The Medication Administration Record (MAR) indicated the resident did not receive her scheduled warfarin doses on August 2, 3, 4, 5, 6, 7, 8, and 9, 2013. On 8/10/13 at 7:48 P.M., the nurses notes indicated the resident had not received her warfarin since 7/29/13,		HWD/Designee for accuracy and/or omissions.· In the event discrepancies are noted, the HWD/Designee will notify the resident's physician and their responsible party, and new orders will be received if necessary.· Documentation of discrepancies found will be entered into the resident's clinical record by the Health and Wellness Director/Designee if indicated. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?· Nursing Staff will be re-educated on Anticoagulant Therapy requirements as well as the use of the INR Tracking Form for appropriate residents.· This training will be provided to nurses by the Health and Wellness Director/Designee· This form is to be audited daily for compliance by the second shift nurses who are to review it before any evening Coumadin is administered. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? · The HWD/Designee will be responsible for weekly audits of INR tracking and lab results for all residents who receive Coumadin and who are not receiving INR/Lab services from an outside contractor. · Results of	

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	making it a total of 11 days since her last dose of warfarin was given. The physician was notified and new orders were given. Physicians orders for 8/10/13 indicated to give Coumadin (the brand name of warfarin) 3 milligrams daily starting on 8/10/13 and then to have a PT/INR drawn on Monday 8/12/13, then weekly on Mondays. On 8/10/13 at 11:30 P.M., the nurses notes indicated the resident's Coumadin arrived and was given. The Health and Wellness Director provided a policy on 9/5/13 at 9:40 A.M., titled "Medication & Treatment-General Guidelines for Medication Administration/Assistance" dated 11/2011 and deemed it current and the general guidelines indicated medications are to be given only within the parameters of the physician's orders.		audits will be provided to the Executive Director in the event non-compliance has been noted.· The HWD and ED will then meet to determine if further corrective action is warranted, based on findings.	

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to follow proper sanitation procedures for their appliances, food storage areas, and food preparation equipment. This had the potential to affect all 51 of 51 residents residing in the facility. Findings include : A sanitation observation of the kitchen was completed with the Dining Service Coordinator (DSC) on 9/3/13 at 10:25 A.M. The walk in refrigerator was observed to have some black moist debris on the ceiling close to the exhaust area of the fan. The DSC used his index finger and wiped the area. The substance came off onto his finger. He indicated at this time, the black substance might be from when they had a leak in the pipe near the refrigerator fan. A storage container with white sugar in it had a half dollar sized brown	R000273	R 273 Food and Nutrition Services – Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· Black Moist Debris was found on the ceiling of the refrigerator close to the exhaust fan. The refrigerator was immediately emptied and power washed after made aware of the alleged deficient practice.· The storage container with white sugar had a half dollar sized brown object in it. The sugar inside the storage container was disposed of immediately and the container was sanitized. · The rack where cookie sheets, mixing bowls, and serving pans were stacked was observed being wet. The pots and pans were washed again and sanitized and placed appropriately on the shelves to allow for air drying. · The dry storage area where food and condiments were stacked had scattered debris behind all of the racks. The racks were pulled and staff cleaned behind and power sprayed the area that evening.· First floor kitchenette was observed to have dried food debris on the bottom of	10/04/2013

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	object in it. The DSC indicated at this time he would expect staff to throw out all of the sugar and clean out the container if there was anything like that in the storage container. The rack where the cookie sheets, mixing bowls, and serving pans were stacked was observed. There were 3 pans, 7 bowls, and 2 large cookie sheets noted to have a clear substance running off of them after they were picked up. The DSC indicated at this time the pans were wet. The dry storage area where food and condiments were stacked had scattered debris behind all of the racks. The DSC indicated at this time the staff were to clean these areas up daily, however, the floor was visibly soiled. The first floor kitchenette area that serves the residents from the first and second floors was observed to have a freezer with dried food debris on the bottom of the freezer. The DSC indicated staff were to use the laminated cleaning list and complete all the cleaning items daily. After the staff clean the areas, he rechecks the areas to ensure they are done. He indicated they did not have a		the freezer. The freezer was emptied and cleaned by staff immediately. · Two associates were observed not cleaning the food thermometers in a consistent manner. All dining staff was in-serviced on proper sanitation of thermometers. The DSC will ensure that alcohol swabs are available for all meals. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?· All residents have the potential to be affected by the alleged deficient practices. · The walk-in refrigerator was emptied and power washed. · The sugar inside the storage container was disposed of immediately and the container was sanitized. · The pots and pans were washed again and sanitized and placed appropriately on the shelves to allow for air drying.· The racks were pulled and staff cleaned behind and power sprayed the area that evening.· The freezer was emptied and cleaned by staff immediately. · All dining staff was in-serviced on proper sanitation of thermometers. The DSC will ensure that alcohol swabs are available for all meals. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does	

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	completed cleaning list for this kitchenette area. Cook # 3 and the DSC checked the temperatures of the food on 9/3/13 at 11:45 A.M. Cook #3 checked the beef and cabbage with the analog food thermometer. She was then told by the DSC to dip the thermometer into the sanitizer bucket. Cook #3 did this and then took a clean paper towel and dried the analog thermometer. She then checked the temperature of the potatoes and repeated process of dipping the thermometer into the sanitizer bucket, then wiped the thermometer off with the same paper towel. She continued to use this process in checking the rest of the food items. A following observation of temperature checks was conducted at 12:05 P.M. Cook # 3 with the DSC present found alcohol wipes and used a new one each time she checked the different food items. She only allowed two seconds in between the wiping off of the thermometer and then sticking it into the next food item. Dietary Aide #2 was observed checking temperatures with the DSC present at 12:30 P.M. The aide took her thermometer after checking the		not recur?· All dining services staff have been assigned cleaning schedules. In addition, the dining services staff will be educated on proper handling of pots and pans after washing to ensure the pots and pans air dry properly before being used again. They were also in-serviced on the Brookdale Policy for "thermometer use". How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?· A Dining Services Cleaning schedule has been implemented for all dining and kitchen areas. The schedule and affected areas will be audited by the DSC weekly x 1 month and then monthly thereafter until the alleged deficient practice does not recur.· A Food storage container audit tool will be completed weekly x 1 month and then monthly thereafter until the alleged deficient practice does not recur. · A dish air dry audit tool will be completed daily x 1 month and then monthly until the alleged deficient practice does not recur.· A food thermometer audit tool will be completed at each meal daily x 1 week, then weekly until the alleged deficient practice does not recur.· Results of audits will be reviewed by the Executive Director on a weekly to monthly basis to monitor for continued compliance. · In the event a	

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	first food item and then ran it under hot water and wiped the thermometer off with a paper towel. She continued this process with the rest of the food items while she let the hot water run to rinse off her thermometer. During an interview with Dietary Aid #2, she indicated she usually uses alcohol wipes to clean off her thermometer, but there were not any available. A policy titled, "Thermometer Use" dated 12/12, indicated, "...1. Wash, rinse and sanitize and air-dry thermometers before and after each use. An alcohol swab should be used for sanitizing and then allowed to air dry before inserting into food...." A request was made to the DSC on 9/3/13 at 12:45 P.M. for a cleaning list and schedules, as of the exit on 9/5/13 none were provided.		non-compliance is noted, the ED will designate next steps and monitor results.	

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R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to have complete documentation for 1 of 9 records reviewed for documentation. (Resident #15) Findings include: Resident #15's record was reviewed on 9/4/13 at 11 A.M. Diagnoses included, but were not limited to, dementia, failure to thrive and high blood pressure. The Medication Administration Record for July 2013 indicated the resident received Ativan 0.5 milligrams on 7/24/13. The nurses notes dated 7/25/13 at 11:00 A.M., indicated, "...resident very lethargic after Ativan given. Called [Doctors name]...Received order for Ativan 0.25 milligrams before shower or for increased agitation...." There was no documentation in the nurses notes regarding any behaviors of	R000349	R 349-Clinical Records Non-complianceWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?· Resident #15: This hospice resident continues with orders for a reduced dose of Ativan to be used on an “as needed” basis for increased agitation.· How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?· Other residents with “prn” (as needed) orders for anxiolytics have the potential to be affected by the alleged deficient action. · Residents with such orders are reviewed by consultant pharmacists every 60 days for potential drug reduction or discontinuation for non-use after 90 days.· The Health and Wellness Director / Nurse Designee completes a Psychotropic Medication Review with each new service plan (PSP)	10/04/2013

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	agitation or concerns related to the resident during her shower. During an interview with the Health and Wellness Director on 9/4/13 at 11:00 A.M., she indicated the hospice staff had concerns with the resident's agitation during bed baths. The hospice staff had decided, after it was requested by the family, for something to help calm the resident before the resident was given a shower. She indicated these issues were not documented in the nurses notes.		completed or every 6 months and with condition change. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?· The Health and Wellness Director/Nurse will inservice nurses on appropriate documentation for the use of “prn” (as needed) medications.· Such documentation is to include other non-medication related attempts to alleviate the behavioral expression prior to administering an anxiolytic medication. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?· The Health and Wellness Director/Designee will audit “prn” anxiolytic administration practices twice monthly to review the clinical record for appropriate documentation and follow-up notes.· In the event non-compliance with documentation requirements is noted, the HWD will present corrective action notices to the nurses involved. · Such corrective action may include additional training, suspension, and up to termination of employment for repeated infractions or omissions.· Audit findings will be provided to the Executive Director to determine if additional corrective	

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			action will be required.	